Kansas Department of Health and Environment

COMPREHENSIVE SCHOOL HEALTH SERVICES CENTER INITIATIVE

Grant Application Guidance

2002-2003

Bureau for Children, Youth & Families

Note: This document is a complete kit. The necessary forms are enclosed with this document. Read the entire document carefully before starting to prepare an application.

GENERAL INFORMATION

Introduction

This application guidance is to inform the potential applicants of the potential for availability of funds to support grants for the purpose of establishing and operating a Comprehensive School Health Center. Funds to support this initiative have been requested for SFY 2002 to the Kansas Department of Health and Environment (KDHE).

Purpose

The purpose of this initiative is to assist school districts and community agencies with the costs of planning, establishing, and operating Comprehensive School Health Services Centers in order to

- promote the optimum health of Kansas children, youth and families
- reduce the incidence of morbidity and mortality associated with decreased access to primary prevention, health promotion, and direct primary care services, including oral health
- decrease the number of school and work days missed for children, youth and families related to acute illness and chronic disease
- improve access to mental health services for children, youth and families
- improve systems coordination and remove barriers created by categorical programs and funding
- improve service delivery, data collection and epidemiological capacity at the local level in order to improve the products of analyses for state and community problem solving

Funding and Grant Period

Fiscal Year 2002 State General Funds in the amount of 279,093 have been requested for this program.

The grant period will be July 1, 2002 to June 30, 2003. KDHE expects to award one to two grants for a four year period in addition to the three projects currently funded. Initial funding for *new* projects funded this year is expected to be available in the amount of approximately $84,000. Continuation of grant funding for the second and subsequent years of projects will be dependent on satisfactory performance and capacity to meet cost participation goals. Grant award amounts will decrease by 25% the second year, 50% the third year, and 75% the fourth year. Grantees must develop and implement a plan for third party reimbursement for services. Local revenue and additional grant assistance should also be pursued.

Local matching funds must be equal to or greater than 30% of grant funds awarded for the first year of the grant. The local match must increase in the second and subsequent years as state and federal funding decreases.

Eligible Applicants

This is a competitive grant application process. Eligible entities include targeted school districts with a large percentage of children and youth identified as high risk (percentage of children and youth receiving free and reduced lunches > 50%) and KDHE epidemiological data referencing decreased access to primary and specialty care, and increased morbidity and mortality. The following school districts and their corresponding health departments have been targeted to submit applications:

- Elk Valley USD 283/Elk County HD
- Kansas City, Kansas USD 500/Wyandotte County HD
- Dodge City USD 443/Ford County HD
- Rolla USD 217/Morton County HD
- Eastern Heights USD 324/Phillips County HD
- Stafford USD 349/Stafford County HD **(currently funded)**
- Wichita USD 259/Sedgwick County HD
- Atchison Public Schools USD 409/Atchison County Office **(currently funded)**
- South Brown County USD 430/NEK HD
- Geary County Schools USD 475/Geary County HD **(currently funded)**

Pre-Application Conference

A Pre-Application Conference will be held on Friday, February 27, 2002 fom 1:00 to 4:00 at the KDHE, 1000 S.W. Jackson, Topeka, Kansas, Suite 220 to answer questions regarding the grant application.

Attendance is **not** mandatory in order to submit a grant application.

KDHE personnel will address any questions or comments raised by potential applicants during the Pre-Application Conference.

The Grant Application Guidance will be used as the conference agenda. Potential applicants should bring their copies of the guidance to the Pre-Application Conference.

Pre-Application Conference Attendance Confirmation

Those planning to attend the Pre-Application Conference are asked to contact Julie Taylor BSN, MEd., Child and School Health Consultant, Bureau for Children, Youth and Families (BCYF), KDHE, (785) 291-7433, e-mail jtaylor@kdhe.state.ks.us by February 25, 2002.

Those who do not plan to attend the preapplication conference may contact the above individual for technical assistance

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PROJECT REQUIREMENTS

The following is a description of project requirements and a guide for development of the grant application.

Full Time Professional School Nurse

To be considered for funding, proposals must maximize the utilization of a full time, qualified and appropriately certified professional school nurse to coordinate essential core services, including triage, treatment, management of chronic disease states, communication with primary care providers of record, health promotion and education, and development of Individualized Health Care Plans (IHP) as appropriate. **Describe your plan to integrate your Comprehensive School Health Services model into the practice of professional school nursing.** For additional information on the role, education and licensure of the school nurse, access the National Association of School Nurses website at http://www.nasn.org/

Services

The following services must be provided on site or through the use of technology or other interventions to expedite appropriate care and decrease/eliminate school and work time missed for both students and staff:

- routine vision and audiology screening, and follow up
- immunizations
- health screening assessments (including EPSDT screens and CHASE)/referrals and follow up
- health education and health promotion activities targeted to both identified risk behaviors and the general school population
- implementation of the **Bright Futures Guidelines** for Health Supervision for all staff providing direct services for infants, children and adolescents
- nutrition education and school nutrition program advocacy
- family and community involvement
- staff wellness programs and initiatives
- dental screening/referrals and follow up
- medication evaluations and follow up
- mental health screening/counseling/referrals and follow up
- diagnosis and treatment of acute illness/referrals and follow up
- management of chronic disease states/referrals and follow up

Describe your plan for providing these basic services

Outcomes, Indicators and Center Programs

The proposed approach for providing Comprehensive School Health Services should be described in terms of measurable outcomes and specific measurable indicators of progress.

KDHE has initiated a state needs assessment process that has identified priority needs for all Maternal Child Health Programs.

Select at least five of the following State Needs Assessment Priorities specific to children and adolescents, and children with special health care needs (CSHCN) to guide the development of Center initiatives over the funding period.

- improving access to all aspects of primary health care
- improving access to all aspects of health care for CSHCN
- reducing unintentional injuries
- reducing intentional injuries
- increasing proper nutrition and physical activity
- developing oral health capacity and improving access to services
- developing behavior health infrastructure and improving access to services
- improving systems coordination and removing barriers caused by categorical programs and funding.

List at least three educational priorities directly impacted by child/adolescent/staff physical and mental health and the management of chronic disease states that the program will target as outcomes over the funding period. **Indicate how the program proposes to intervene in order to improve educational as well as health status outcomes.** These may include but certainly are in no way limited to:

- student/staff absenteeism rates
- standardized test scores
- reduction of student behavior referrals, suspension, and expulsions
- school violence/bullying
- general student achievement (grades, honor roll participation, etc)
- immunizations/exclusions
- inclusion/CSHCN

Based on the health and educational outcomes, selected, **list the indicators** that will be used to gauge progress toward the completion of program outcomes. These, should, to the extent possible be clear and measurable indicators and should be assessed on a semiannual basis by funded projects, and used to direct future activities and funding allocations. For example, these may include such indicators as, but are in no way limited to:

- number of oral health screens done
- percentage of students with dental health goals/referrals/follow up
- number of students referred for behavioral concerns
- percentage of students with unintentional injuries sustained on school grounds during regular school hours
- number of school days missed related to acute illness
- number of parent work days missed related to student illness/exclusion
- incidence of otitis media identified, treated and resolved
- incidence of student-on-student violence

For each indicator, **list the source of the data** to be used to assess progress. For example:

- school attendance records
- student/parent survey
- encounter data
- immunization records
- parent/teacher report
- KDOE website data
- health history, etc.

Problem Statement

Based on the needs assessment, **provide a problem statement** that succinctly summarizes the needs of the target population in relation to the overall health **and educational** outcomes. The Comprehensive School Health Services delivery model should be directed toward the elimination of health **and educational** barriers through the integration of a true medical home into the school setting (see Attachment I). Integration of a medical home does **not** mean the school health center **becomes** the medical home. Integration reflects the mutual recognition of the need for partnerships and multidisciplinary efforts directed in a coordinated manner, with a shared but secure and confidential medical record in order to improve student health and educational outcomes.

Advisory Committee

The advisory committee will share responsibility for the identification and maximization of resources and community ownership to sustain project services. Membership of the committee should include individuals from the following groups:

- consumers (students and parents)
- education (district and school site)
- local pediatric and/or family practice provider
- medicaid/SCHIPS agency representative
- private health care insurance representative

- local health department
- local elected official
- social service agency
- local business community
- faith community

Though all groups do not have to be represented on the advisory committee, parents and students *must* be included. Completeness of membership reflects the ability of grantee to perform within the targeted area and its ability to build community partnerships. **Provide a list of proposed advisory committee members** and their representative agencies, with a letter of interest when possible, to serve on the advisory committee.

The advisory committee should meet on a monthly basis to generate an action plan for the coming weeks. Activities of the advisory committee should be incorporated into the annual project report.

In cases where a community consortium with similar goals of providing Comprehensive School Health Services in the target population already exists, a review of those services and how projects will avoid duplication of services should be included in this part of the application.

Delivery Mechanism

Describe the proposed service delivery mechanism to provide primary and mental health care and social services (e.g. ARNP and/or physician on site, telemedicine/videoconference linkage to primary care providers, mental health counselors, psychiatrists, social services, community mental health providers, etc.) and **percentage of time** collaborative staff will dedicate to the Comprehensive School Health Center. This should reflect the integration of a medical home for each student into the school setting, not the existence of a second medical home at the school. **Be sure to plan for a mechanism for sharing information and ensuring confidentiality and security of medical records.**

Narrative

Provide a detailed description of your plan for each of the following components

- **A plan to foster collaboration** amount families, school staff, and multiple community agencies to improve coordination and integration of primary prevention and health promotion, direct primary care services, mental health and social services at the school site.
- **Describe linkages** to existing health care resource
- **Plan for delivery of 24/365 care** including after hours, weekend, holiday and summers.
- **Evidence of support** from state and local provider and payer systems

- **Describe referral system and outreach methods**
- **Describe qualifications and certifications of personnel** (may attach curricula vitae here)
- **Describe supervision and training** of paraprofessional an/or unlicensed assistive personnel
- **Describe the policy for ensuring confidentiality** of client records. Specify what information is to be shared with school staff (and/or parents for adolescents) and under what circumstances. Describe the technology available to ensure confidentiality, including dedicated phone, fax, computer connections, etc.
- **Describe how you plan to communicate with primary care providers and specialists**
- **Describe you plan for ongoing professional development of staff**
- **Describe the process for ensuring continuous quality improvement** for the Comprehensive School Health Center. Include developmentally appropriate methodologies for assessing family and student satisfaction, as well as a means of assessing satisfaction of all collaborative partners on an ongoing basis
- **Detailed budget and budget justification** (Attachment II)
- **Describe your plan to ensure cultural competence** in interactions at the Comprehensive School Health Services Center

Initial Time Line

Grant Award/finalization of plan and project scope with KDHE — June 2002
integrated Services workshop — August 2002

Grantee must agree to attend the above workshop

Data Collection

Grantees will work with KDHE to develop an appropriate database over the funding period. Specific requirements are outlined in the purple Grant Application Guidelines.

Program Evaluation

Program evaluation will be done at the state level by KDHE through a review of project data. The epidemiologist for KDHE's Bureau of Children, Youth & Families will work with the program manager and local projects to ensure data is sufficient to complete the program evaluation.

REPORTING REQUIREMENTS

Fiscal and Program Narrative Report Submission

All fiscal and narrative reports are to be mailed to:

Gordon Foster
KDHE/Internal Management, Accounting Services
1000 SW Jackson, Suite 570
Topeka, KS 66612

Fiscal Reports

Grantee will submit to KDHE an "Affidavit of Expenditures" to reflect expenditures for the following periods of time: **July 1, 2002 through December 31, 2002 (due January 15, 2003); January 1, 2003 through June 30, 2003 (due July 15, 2003).** Expenses are to be itemized as they relate to the budget that will be appended to the grant contract.

Program Narrative

Grantee will submit to KDHE one program narrative for the period of July 1, 2002 through June 30, 2003 (due July 15, 2003).

CONTRACTUAL REQUIREMENTS

Contractual Provisions

Note: The following information is an abbreviated overview of the contractual provisions and should not be interpreted as the full language of any contract relating to the Comprehensive School Health Services Initiative.

Applicant is referred to the State of Kansas, Department of Administration's DA-146a, "Contractual Provisions Attachment" Appendix C. (Attachment III)

Grantee will agree to obtain an audit in accordance with the Federal Single Audit Act of 1984 and OMB Circular No. A-133, Audits of States, Local Governments and Non-Profit Organizations, and submit a copy of the single agency audit report to the State Agency.

Grantee will permit access, upon written request, to the Secretary of KDHE or Kansas Legislative Post Audit, to any local agency documents and other records necessary to certify compliance with State Agency Grant Awards, Kansas Legislative Appropriations, Kansas Statute and Federal Grant Acts and Regulations.

Grantee will hold confidential all personal client information obtained or received from recipients of services under this contract and agrees not to disclose client information except in statistical, summary or other forms that do not identify individual clients.

Grantee agrees to comply with all relevant federal requirements including, but not limited to: Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Title IX of the Educational Amendments of 1972, Title VII of the Civil

Rights Act of 1964, Recipient Certification requirements of the Drug Free Workplace Act of 1988, Federal Anti-Lobbying Act of 1990, the Federal Pro-Children Act of 1994 and to submit a signed certification regarding environmental tobacco smoke to KDHE, which will be incorporated by reference in the contract.

Grantee will agree to comply with Kansas statutes, rules and regulations pertaining to public health.

Grantee will not use grant funds to supplant other Local Agency funds.

APPLICATION SUBMISSION/REVIEW PROCESS

Application Submission

Applications must be postmarked by midnight, March 12 , 2002 per the State Grant Application Guidelines.
Contact Julie Taylor 785-296-7433 or jtaylor @kdhe.state.ks.us with questions or concerns.

Applications may be hand delivered or mailed to:

Children and Families Section
Attn: Comprehensive School Health Services Center Initiative
Kansas Department of Health and Environment
1000 SW Jackson, Suite 220
Topeka, Kansas 66612

An original and four (4) copies of the application packet are to be submitted. All copies will include the "Application for Grant" cover page (Attachment IV) and be single sided and unbound.

Application Organization

The application should be assembled in the order shown below:

- The "Application for Grant" cover page (Attachment IV)
- The "Detailed Budget for Grant Funds (Attachment II)
- The budget narrative
- The program narrative
- Appendices (if needed)

Format Requirements for the Application

Applications must be typed on white paper with a one (1) inch margin and at least a twelve (12) font pitch.

The program narrative should not exceed twenty (20) pages in length. This includes any referenced charts or figures but does not include the "Application for Grant " cover page, the budget revision page, the budget narrative or appendices.

Each distinctive section of the program narrative should be titled.
Any attachments and supporting documents should be included in the appendix.

Application Technical Assistance

Questions regarding the specifications, requirements and review process should be directed to: Julie Taylor BSN, MEd., NCSN, Childand School Health Consultant, Bureau for Children, Youth & Families (CYF), KDHE, (785) 296-7433, e-mail jtaylor@kdhe.state.ks.us.

Applicants are advised that the only official position of KDHE is that position which is stated within the Comprehensive School Health Services Center Initiative Application Guidance. No other means of communication, whether oral or written, will be construed as a formal or official response or statement on behalf of KDHE.

Applicants are requested not to contact any other employee of the Department concerning the application and review process.

Application Review

Applications will be reviewed by an interdisciplinary review committee to determine if the application is responsible to the requirements listed in the application guidance. Review criteria include:

- integrates as opposed to co-locates services at the school site
- maximizes the existing resources of the school and community
- describes the priority needs in the school community as they relate to the state needs assessment priorities
- improves systems coordination and removes barriers created by categorical programs and funding
- describes the plan/capacity for meeting cost participation goals as specified
- addresses the project requirements as outlined
- demonstrates staff are qualified to establish and operate a culturally competent School Health Center

Grant Award Notification

Any grant award announcement or contract offer resulting from this process will be in writing from KDHE by May 30, 2002, barring unforeseen fiscal circumstances that may delay or prevent such announcement.

Applications are reviewed on a competitive basis, and, as a result, all applicants may not receive an award. KDHE reserves the right to accept any application, to

reject any or all applications, in full or in part, and to waive irregularities and/or formalities as deemed appropriate.

Attachment I

American Academy of Pediatrics Medical Home Policy Statement

American Academy of Pediatrics School Health Centers and Other Integrated Health Services Policy Statement

The Medical Home (RE9262)

AMERICAN ACADEMY OF PEDIATRICS

Ad Hoc Task Force on Definition of the Medical Home

The American Academy of Pediatrics believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the "medical home" and describe the care that has traditionally been provided by pediatricians in an office setting. In contrast, care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often less effective and more costly.

We should strive to attain a "medical home" for all of our children. Although geographic barriers, personnel constraints, practice patterns, and economic and social forces make the ideal "medical home" unobtainable for many children, we believe that comprehensive health care of infants, children, and adolescents, wherever delivered, should encompass the following services:

1. Provision of preventive care including, but not restricted to, immunizations, growth and development assessments, appropriate screening, health care supervision, and patient and parental counseling about health and psychosocial issues.

2. Assurance of ambulatory and inpatient care for acute illnesses, 24 hours a day, 7 days a week; during the working day, after hours, on weekends, 52 weeks of the year.

3. Provision of care over an extended period of time to enhance continuity.

4. Identification of the need for subspecialty consultation and referrals and knowing from whom and where these can be obtained. Provision of medical information about the patient to the consultant. Evaluation of the consultant's recommendations, implementation of recommendations that are indicated and appropriate, and interpretation of these to the family.

5. Interaction with school and community agencies to be certain that special health needs of the individual child are addressed.

6. Maintenance of a central record and data base containing all pertinent medical information about the child, including information about hospitalizations. This record should be accessible, but confidentiality must be assured.

Medical care of infants, children, and adolescents must sometimes be provided in locations other than physician's offices. However, unless these locations provide all of the services listed above, they do not meet the definition of a medical home.
Other venues for children's care include hospital outpatient clinics, school-based and school-linked clinics, community health centers, health department clinics, and others. However, wherever given, medical care coverage must be constantly available. It

should be supervised by physicians well-trained in primary pediatric medicine, preferably pediatricians. Whenever possible, the physician should be physically present where the care is provided; but it may be necessary for the physician to direct other health care providers such as nurses, nurse practitioners, and physician assistants off site. Whether physically present or not, the physician must act as the child's advocate and assume control and ultimate responsibility for the care that is provided.

AD HOC TASK FORCE ON DEFINITION OF THE MEDICAL HOME
Michael D. Dickens, MD
John L. Green, MD
Alan E. Kohrt, MD
Howard A. Pearson, MD

The Medical Home Statement Addendum: Pediatric Primary Health Care (RE9262)

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

PEDIATRICS (ISSN 0031 4005). Copyright (c) 1992 by the American Academy of Pediatrics.

School Health Centers and Other Integrated School Health Services (RE0030)

Committee on School Health

ABSTRACT. This statement offers guidelines on the integration of expanded school health services, including school-based and school-linked health centers, into community-based health care systems. Expanded school health services should be integrated so that they enhance accessibility, provide high-quality health care, link children to a medical home, are financially sustainable, and address both long- and short-term needs of children and adolescents.

BACKGROUND INFORMATION

There are a number of core screening, diagnostic, treatment, and health counseling services that every school should provide[1] and that most schools already do provide.[2] These include management of medical emergencies, medication delivery, services for children with special health care needs, referral of common health problems (such as injury, asthma, behavioral and emotional difficulties), and health screens (such as vision and hearing screens).

Increasingly, schools are used as health access sites for students to receive increased and improved access to care that they are not receiving elsewhere.[3-5] A program with expanded health services may provide, for example, on-site immunizations, full health histories and physical examinations, or on-site therapy for children with special mental health needs. These services provide numerous benefits and potential benefits, including:

1.Students of all ages in some rural areas do not have reasonable access to any other medical services.

2.Less classroom time is lost to travel time.

3.Follow-up compliance may be better.

4.Adolescents, for a variety of reasons (eg, emancipation, independence, desire for confidentiality), often will not seek out or take advantage of services in traditional settings.[6]

5.Families that are not accustomed to using primary or preventive services available to them in traditional settings can be taught to use them through schools.

6.Behavioral risk assessments and ongoing preventive strategies that address major causes of youth mortality (suicide, homicide, accidental injury) often require a degree of access to health and mental health services that schools can provide. Mental health services on a school site can reduce time away from school to travel to regular mental health appointments. When a mental health clinic's presence on a school site is accompanied by close collaboration with school staff, then enhanced behavioral observation and clinical management also occur.

Schools that offer these expanded health services may do so through either school-linked or school-based health centers.
"School-based" and "school-linked" are terms used to distinguish between services delivered on school campuses from those coordinated at the school but delivered off campus. In school-linked models, school health professionals collaborate with local

community clinics, hospitals, and/or other health professionals and agencies. Some schools have characteristics of both school-linked and school-based models, such as mobile medical service vans that park intermittently outside various school sites.

Health centers' services range from full comprehensive services (preventive and acute care as well as mental health services) to only one component of this care. Many operate from a regular school health office; others are modern, sophisticated, and well-equipped clinics. Some offer services around the clock and every day, while in others a health team from a local practice or clinic visits the school site one half-day per week. Often school staffs do not provide health services; rather community health professionals provide services on a school site through an interagency agreement. The rich diversity of existing models[7] does not allow for simplistic categorization. This diversity exists at every level of education, from preschool to high school.

It is essential that health services provided by the educational sector are integrated with health education, social services, and health services provided elsewhere in the community. It is important that school-based services should not supplant services that could be delivered elsewhere, unless that is part of the agreed-on design. The American Academy of Pediatrics believes that all children and adolescents require a "medical home."[8] All models of health care delivery should aspire to provide health supervision and medical care that is continuous, comprehensive, family centered, culturally sensitive, compassionate, coordinated, and provided by a pediatrician or another physician or health care provider who is well-trained in child and adolescent health.

CHALLENGES

Some challenges for school health centers or for any model of expanded school health services are:

1.There is great variability in the degree to which school-based and school-linked services integrate with the medical home and to other community services and the degree to which they complement community services to meet student needs.

2.There is great variability in the degree to which school-based and school-linked services integrate with other components of the school system. School health centers cannot optimally assist students unless they are closely integrated with the school nurse (where one exists), the school's health educational program, and with other traditional or core school programs.[9]

3.Expanded school health services carry inherent and unique issues of patient confidentiality, consent, compliance, and continuity that need different solutions than they would in traditional health care settings and in schools without expanded health services.

4.Fair reimbursement for school-delivered health services is frequently difficult to achieve.[10]

If not addressed, all these issues can remain emotionally, morally, and politically charged, often paralyzing efforts to establish the best and most sustainable intervention and prevention programs. By adhering to a few basic guidelines, schools and their communities may avoid costly redundancies in health care delivery and unnecessary gaps in services.

INTEGRATED SCHOOL HEALTH SERVICES

"Integrated school health services" refers to a community-based approach to identifying the needs of children and youth, then matching them to available resources in the educational, health care, and social services sectors. All stakeholders, usually the school system, community health care providers, families, social service agencies, health plans, managed care organizations, and public health departments, must first decide on common goals and objectives for improving educational performance and child and adolescent health.

This should be based on a comprehensive community needs assessment—the first step in any decision to expand school health services.[1] The district or school and local child health and social services professionals must work closely with parents and community groups to evaluate the current status of child health and determine unmet needs. Services already available to children should not be duplicated unless the school is considered by stakeholders to be the only way to make these services accessible. A needs assessment should be developed that is supported by credible data and conducted by those knowledgeable of existing health care resources and health data in their community. It should be an ongoing process built permanently into the program.

Integrated school health services should have a governing structure that establishes communication among various professional disciplines and agencies, and designs and guides the service delivery program. Membership is at an authority level that ensures appropriate agency participation. Representatives in the administrative structure include students (especially adolescents), parents, pediatricians and other health care providers, school nursing personnel, local health department representatives, school administrators, and educators. It may also include faculty of local institutions of higher education, social service providers, representatives of managed care organizations, public and private mental health care agencies, and representatives of local government and local business, cultural, ethnic, and religious communities. In an integrated school health services plan, school-nursing personnel and, if one exists, the school's own physician or medical consultant, should be involved in the planning and direction of the program.

Once a needs assessment is complete and stakeholders are established, the extent and type of services provided through an integrated school health service program needs to be determined. Services might include any of the following: screening for acute and chronic health problems; preventive health care (disease prevention and health promotion); acute illness care; family planning and reproductive health care; mental health services; social services; substance abuse counseling; dental services; nutritional services; health counseling and education; and transportation to a traditional provider. The decision to choose an enhanced school health office, to link with a nearby community health agency, or to set up a school-based health center is based on what can best complement existing resources.

Last in the process of setting up an integrated school health services plan are formally written agreements and goals. To protect the collaboration from the threats of turf and control conflicts between agencies or to provide a more efficient management structure, some communities may choose to establish a nonprofit corporation to administer the program. More typically the school, school district, or one of the community health or social entities becomes the fiscal and lead agency. In these formal agreements, a formalized communication plan and a plan for collaboration with the medical home (provider or clinic) and health and social service agencies in the community should be included.

School-based health services are often provided by certified nurse practitioners, physician assistants, or licensed or credentialed mental health professionals (social workers, psychologists, etc). Pediatricians or other physicians from a community practice or clinic or from the public health sector frequently serve as medical directors.

The medical director, along with the school principal and school-based health professionals, decide on day-to-day activities, protocols, and quality assurance. The activities of the clinical personnel should reflect the decisions of the broader-based governing structure as described above. If primary medical services are delivered on a school site by a nonphysician provider, telephone back-up from a pediatrician or other physician should be available at all times. It is important to establish where students will receive after-hours and weekend telephone and triage services. Onsite consultation, supervision, and quality assurance with periodic chart review are part of an integrated school health services plan.

Integrated school health service programs require a sound financial base. Sources of funds may include private health insurance plans; traditional school health funds; an Early and Periodic Screening, Diagnostic, and Treatment program; Medicaid; Chapter I; Title X; Title XX; and other government programs.[11]

Among populations with high managed care penetration, there are additional considerations and possibilities.[12] Students enrolled in managed care plans have primary care providers assigned to them. Typically these providers are outside of the school system, they receive monthly capitation funds, and they are expected to provide all primary health care. A number of financial arrangements are possible for this population.[13-17] Health plans may agree to compensate school-based clinical activities on a fee-for-service basis, while still compensating their community-based providers at the same or a reduced amount. School clinics may also be compensated on a capitated basis. In some communities, health plans expect the school's reimbursement to come not from them, but directly from the students' capitated health care providers. In this latter model, there is usually a large portion of the student population that shares one common medical group or community clinic as its primary care provider. These clinicians or their designees come onto the school site to provide services for their patients. The school operates as a satellite location for a traditional primary care agency. In this model, the need to reimburse school providers through a separate agreement with managed care organizations is not necessary. Often, mental health services are contracted out or carved out from managed care health plans, so that mental health providers who work on school sites are compensated no differently than those working in traditional off-school site settings.

Advocacy for new mechanisms of health care financing at both state and national levels may be needed to ensure that dollars flow to all health and human service providers so that there is a seamless web of services for the child and family.

RECOMMENDATIONS

The Academy recommends that the medical service component of an integrated and comprehensive school health program meet the provisions of the current policy statements and manuals of the Academy, ie, "The Medical Home,"[8] School Health: Policy and Practice,[18] "Recommendations for Preventive Pediatric Health Care,"[19] "School Health Assessments,"[20] and "Qualifications and Utilization of Nursing Personnel Delivering Health Services in Schools."[21]

1.School-based health care providers must communicate with each student's existing sources of health care, eg, the primary care provider, when there is one. When necessary, and based on the specific design for that school, arrangements may also be made with neighborhood health programs, mental health programs, and health maintenance organizations. This communication needs to be established at the onset, and may be via telephone, fax, e-mail, or post. Care should be taken not to disrupt existing services.

2.Part of every integrated health services program charter must be to introduce each student and family to a traditional medical home whenever this is possible in a community. An integrated school health program must include activities that prepare the large portion of students who will inevitably graduate or transfer from school each year. Examples of such activities are those that assist families with health insurance eligibility determinations, applications for insurance, selection of a non–school-based primary care provider, and registration at a community-based clinical practice that will serve as the students' medical home. Even if students receive most services at a school health center, families should be taught when and how to make preventive health appointments, to travel to their medical-home site independently, and to become familiar with a permanent primary care provider of their choice.

3.Parents should be encouraged to be primarily and intimately involved in the health education and health supervision of their children.

4.Issues of medical liability and confidentiality should be identified and addressed during a registration process. Typically a standard parent permission form is prepared as a component of registration for the school-based clinic so that students may receive services. At the very least, this should include permission for the school health center to exchange information with the primary care provider and with the school's traditional health staff (eg, school nurse, school counselor) for matters that pertain to a child's well-being at school. If the school's plan includes provisions for adolescents to receive services without parent notification or health plan billing, this too must be addressed at the time of registration.

5.A comprehensive review of existing resources and funding mechanisms must be done, preferably as part of the initial community assessment. Financial support for providers who supply in-school and after-hours health care should be included. Schools should not rely solely on temporary foundation grants. These funds are appropriate to use for start-up costs and to fund health care costs for students ineligible for any health insurance program. A variety of possible models of funding should be explored. Design and choose a system that is acceptable to all parties at financial risk and that does not fragment continuity of care in an attempt to capture dollars. A long-term funding plan is optimally developed before the integrated school health services program is initiated.

6.An ongoing process of evaluation should be incorporated into all integrated school health programs. Programs should adopt clearly stated goals and then design an ongoing data-based needs assessment. Programs must have the means to collect data and establish mechanisms for analysis and reporting. Quality assurance and improvement are important parts of the evaluation. Systematic evaluation should provide information about whether the integrated school health services approach is effective and worth the investment.

SUMMARY

Schools can successfully expand access to health care services for all students, particularly underserved populations, when the program includes careful community assessment and endorsement, is integrated with the school's existing health program, has a sound plan for financial sustainability, and pays adequate attention to quality assurance, evaluation, promotion, and integration with a medical home. School health services can be an effective vehicle for integrating psychosocial care and education with medical care.

Pediatricians practicing in public and private sectors should become actively involved in any community effort to develop an integrated school health services initiative. A well-designed integrated health services program, when coupled with comprehensive school

health education, could significantly advance the state of health of the nation's children, youth, and families.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations,
taking into account individual circumstances, may be appropriate.

Attachment II

Detailed Budget For Grant Funds

Attachment III

Contractual Provisions

State of Kansas
Department of Administration
DA-146a (Rev. 3-00)

CONTRACTUAL PROVISIONS ATTACHMENT

Important: This form contains mandatory contract provisions and must be attached to or incorporated in all copies of any contractual agreement. If it is attached to the vendor/contractor's standard contract form, then that form must be altered to contain the following provision:

"The Provisions found in Contractual Provisions Attachment (Form DA-146a, Rev. 3-00), which is attached hereto, are hereby incorporated in this contract and made a part thereof."

The parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being the _____ day of _____, 20_____.

1. Terms Herein Controlling Provisions: It is expressly agreed that the terms of each and every provision in this attachment shall prevail and control over the terms of any other conflicting provision in any other document relating to and a part of the contract in which this attachment is incorporated.

2. Agreement With Kansas Law: All contractual agreements shall be subject to, governed by , and construed according to the laws of the State of Kansas.

3. Termination Due To Lack Of Funding Appropriation: If, in the judgment of the Director of Accounts and Reports, Department of Administration, sufficient funds are not appropriated to continue the function performed in this agreement and for the payment of the charges hereunder, State may terminate this agreement at the end of its current fiscal year. State agrees to give written notice of termination to contractor at least 30 days prior to the end of its current fiscal year, and shall give such notice for a greater period prior to the end of such fiscal year as may be provided in this contract, except that such notice shall not be required prior to 90 days before the end of such fiscal year. Contractor shall have the right, at the end of such fiscal year, to take possession of any equipment provided State under the contract. State will pay to the contractor all regular contractual payments incurred through the end of such fiscal year, plus contractual charges incidental to the return of any such equipment. Upon termination of the agreement by State, title to any such equipment shall revert to contractor at the end of State's current fiscal year. The termination of the contract pursuant to this paragraph shall not cause any penalty to be charged to the agency or the contractor.

4. Disclaimer Of Liability: Neither the State of Kansas nor any agency thereof shall hold harmless or indemnify any contractor beyond that liability incurred under the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.).

5. Anti-Discrimination Clause : The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111 et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101 et seq.) (ADA) and to not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, or age in the admission or access to, or treatment or employment in, its programs or activities; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration; (f) if it is determined that the contractor has violated applicable provisions of ADA, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration. Parties to this contract understand that the provisions of this paragraph number 5 (with the exception of those provisions relating to the ADA) are not applicable to a contractor who employs fewer than four employees during the term of such contract or whose contracts with the contracting state agency cumulatively total $5,000 or less during the fiscal year of such agency.

6. Acceptance Of Contract: This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.

7. **Arbitration, Damages, Warranties**: Notwithstanding any language to the contrary, no interpretation shall be allowed to find the State or any agency thereof has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, the State of Kansas shall not agree to pay attorney fees and late payment charges beyond those available under the Kansas Prompt Payment Act (K.S.A. 75-6403), and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

8. Representative's Authority To Contract: By signing this contract, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this contract on behalf of the contractor and that the contractor agrees to be bound by the provisions thereof.

9. Responsibility For Taxes: The State of Kansas shall not be responsible for, nor indemnify a contractor for, any federal, state or local taxes which may be imposed or levied upon the subject matter of this contract.

10. Insurance: The State of Kansas shall not be required to purchase, any insurance against loss or damage to any personal property to which this contract relates, nor shall this contract require the State to establish a "self-insurance" fund to protect against any such loss of damage. Subject to the provisions of the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.), the vendor or lessor shall bear the risk of any loss or damage to any personal property in which vendor or lessor holds title.

11. Information: No provision of this contract shall be construed as limiting the Legislative Division of Post Audit from having access to information pursuant to K.S.A. 46-1101 et seq.

Attachment IV

Application for Grant Funds